

November 6, 2012

Brian Thibeau, President
New England Telehealth Consortium

VIA ELECTRONIC FILING

Julie Veach
Chief, Wireline Competition Bureau
Federal Communications Commission
445 12th Street, S.W.
Washington, DC 20554

**Re: Supplemental Comment in WC Docket No. 02-60
New England Telehealth Consortium**

Dear Ms. Veach:

On behalf of the New England Telehealth Consortium, ("NETC"), we would like to briefly supplement the reply comments NETC filed on September 7, 2012 in the Rural Health Care ("RHC") program docket. This supplemental comment addresses potential demand for RHC funding should the Commission apply RHC Pilot Program rules regarding the eligibility of non-rural health care providers ("HCPs") and a discount level of 85% to the proposed Health Broadband Services Program ("HBSP"). Specifically, we offer a funding demand projection based on the average costs over 10 years for HCPs participating in NETC. Because NETC's cost data covers more than 400 eligible HCPs of all sizes across three very rural states – Vermont, New Hampshire, and Maine – we believe the expected per-HCP cost for NETC will be useful as the Commission considers the potential impact of various policy scenarios on the future demand for RHC funding.

Note that NETC's network offers postalized or flat-rate pricing to its members based on the amount of bandwidth HCPs obtain, regardless of geographic location.¹ NETC is leasing connectivity as a service from a local telecommunications provider and, through the competitive bidding process, was able to obtain guaranteed pricing for HCP monthly recurring costs for a period of 10 years. NETC also made significant investments in equipment to manage the network with redundant core routers and an independently managed Network Operations Center ("NOC").²

¹ The benefits of postalized pricing were discussed in our earlier comments and will not be re-addressed here.

² NETC per-HCP costs consist of three components:

In NETC's earlier comments we explained that NETC's rate of RHC expenditures annualizes to about \$6 million per year for the first four years (reflecting funding commitments of \$24.7 million expended over about four years), with a dramatic drop-off in annualized costs beginning in year five. We observed that, even if NETC were to add substantial numbers of new eligible HCPs, the potential draw on the RHC fund is unlikely to increase over the initial 4-year start up period.

In the tables below we project RHC fund demand using NETC's actual costs which are based partly on negotiated postalized rates guaranteed for 10 years. We extrapolate those costs assuming an HBSP that continues the 85% Pilot subsidy level and continues eligibility for non-rural HCPs.³ In the first table, we use the average subsidy for NETC HCPs over ten years and then extrapolate fund demand assuming a total national universe of 10,000 eligible HCPs.⁴ In the second table we use the NETC postalized cost for a 100Mb connection to extrapolate fund demand.⁵

Projecting RHC Demand			
<i>Assuming Continuation of 85% Pilot Program Subsidy and Eligibility for Non-Rural</i>			
Table 1 – Using NETC Average HCP Subsidy Over 10-years			
	NETC Total (428 HCPs)	Subsidy Per Eligible NETC HCP	Projected to 10,000 Eligible HCPs
Total Pilot Program Subsidy (years 1-4)	\$ 24,689,128	\$ 57,685	\$ 576,848,785
Projected HBSP Subsidy (years 5-10)	\$ 10,227,720	\$ 23,897	\$ 238,965,409
Total 10-year Support	\$ 34,916,848	\$ 81,581	\$ 815,814,194
Annualized RHC Support (over 10-years)	\$ 3,491,685	\$ 8,158	\$ 81,581,419

- (1) Installation: Initial non-recurring costs ("NRC") (covering installation and network equipment at the edge and core);
- (2) Edge Connectivity: Monthly recurring costs ("MRC") for connectivity as a service (covering connectivity from HCPs to the NETC network core);
- (3) Network Common: MRC for network common costs (e.g., connectivity services for the redundant network cores, Commodity Internet, Internet2, NOC management, etc.).

³ NETC's percent of non-rural HCP participation is about 28%.

⁴ We based the 10,000 number on public information regarding the nationwide number of health clinics and hospitals. See, e.g., John Gale, Maine Rural Health Research Center, *Ex Parte* Letter, Attachment 1 (Mar. 29, 2012) (indicating 3950 CMS Medicare Certified Rural Health Clinics); American Hospital Association, *Fast Facts*, <http://www.aha.org/research/rc/stat-studies/fast-facts.shtml> (showing about 6000 hospitals nationwide) (last checked Nov. 5, 2012). We recognize that the 10,000 figure includes for-profit entities and excludes potentially eligible HCP types such as Federally Qualified Health Centers; however, our intent is to simply provide a marker showing how far below the cap a relatively aggressive demand scenario will be.

⁵ NETC offers postalized pricing for bandwidth's ranging from T-1 through 1 Gig. The most common NETC connection is 10 Mbs. For illustration purposes we used 100 Mb for this analysis to create a high-demand scenario.

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Table 2 – Using Cost of NETC 100 Mbs Service

	NETC 100 MB service (52 HCPs)	Subsidy Per Eligible NETC HCP	Projected to 10,000 eligible HCPs
Total Pilot Program Subsidy (years 1-4)	\$ 5,387,569.49	\$ 103,607	\$ 1,036,071,055
Projected HBSP Subsidy (years 5-10)	\$ 2,803,758.99	\$ 53,918	\$ 539,184,421
Total 10-year Support	\$ 8,191,328.48	\$ 157,526	\$ 1,575,255,476
Annualized RHC Support (over 10-years)	\$ 819,132.85	\$ 15,753	\$ 157,525,548

The highlighted boxes in the lower right of each table show the extrapolated annual demand on the RHC program. Thus, if something similar to the NETC cost structure is replicated elsewhere, continuing an 85% RHC subsidy and allowing the eligibility of non-rural should not come close to exceeding the \$400 million RHC program cap, even under an aggressive scenario of every HCP obtaining a 100 Mb connection. We of course recognize that states have diverse geographies and cost will vary, but we also believe consortium bidding has already demonstrated the power of competition and there is no reason to doubt that this will continue to dramatically drive down the cost per MB of bandwidth.

Finally, in addition to the demand projections above, the Commission should recognize that while NETC and many pilot projects are proving successful, these networks were not easy to establish. Even with favorable Pilot Program rules providing for 85% subsidies and the eligibility of non-rural HCPs (for networks with non-deminimis rural HCP participation), each network required a tremendous amount of time and commitment in the form of financial and human resources to launch and become successful.⁶ This experience suggests little reason to assume successful networks will quickly emerge with the new HBSP program. This will ensure the Commission has time to adjust policies if it becomes necessary.

We trust you will find this information helpful.

Sincerely,

Brian Thibeau, President
New England Telehealth Consortium

Cc Linda Oliver, Esq.

⁶ Indeed, while the Pilot Program offered over \$400 million in total funding beginning in 2007, USAC reported earlier this year that by December 2011 – four years later – less than 25% of those funds had been disbursed. See Letter from Craig Davis, Vice President, Rural Health Care Division, Universal Service Administrative Company (“USAC”), to Sharon Gillett, Chief, WCB, FCC, WC Docket No. 02-60, at 3 (May 4, 2012) (reporting cumulative disbursements of \$95 million through December 2011).